

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3155

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 6 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 7148 Askew
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TONY ROY RINEHART

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced SO

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 1 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

6 19 _____ hr. _____ min.

9. Birthplace K.C. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business John Rinehart

12. Name K.C. Mo

13. Birthplace Florence Laftis
(City, town, or county) (State or foreign country)

14. Maiden name K.C. Mo

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant John Rinehart

(b) Address 7148 Askew

17. (a) Burial (b) Date thereof 8/22/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem

18. (a) Signature of funeral director Schbita

(b) Address K.C. Mo

19. (a) 8-22-42 (b) N. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20th
year 1942 hour 1:00 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 8-19-42, 19____, to 8-20-42, 19____;
that I last saw him alive on 8-20-42, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
CAUSE OF DEATH DEFERRED PENDING FURTHER INVESTIGATION BY PATHOLOGICAL DEPARTMENT

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

CAUSE OF DEATH DEFERRED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wesley R. Thout (M.D. or other) _____
Address Med. Dir. K.C. General Hospital Date signed _____

48
3
8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No. 2560
working under my personal supervision.

Signed.....

Ray E. Snow

.....
Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3155

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: General Hospital # 9
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No. 7148 Astew
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Tony Roy Rinehart

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 19 hr. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9/22/42 (b) M. H. Brown
(Date received local registrar) (Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug. day 20th
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death Death Cause of unknown.

Due to.....

Due to..... 200c

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-26481